



# *Developing Communalities: Family-centered Programs to Improve Children's Health and Well-being*

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**Abstract.** *Despite decades of enormous investment in research and public programs, the United States continues to face pandemics of preventable health problems such as low birth weight, teenage pregnancy, drug abuse, and interpersonal violence. With some justification, these problems have been blamed on the failings of families. The reasons why families may function poorly in their child-rearing roles have not been coherently or vigorously addressed by our social policies; sometimes these policies have aggravated the problems. This paper provides background to allow a better understanding of families' role in the social determination of children's health, and argues for programs and policies that assist families through the creation of social supports embedded in communities that are characterized by trust and mutual obligation.*

## **Introduction**

As the nation engages in a major restructuring of societal responsibilities, it is timely and appropriate to consider the impact of social structures on health in general and children's health in particular. Medical care makes only a modest contribution to children's health status. The primary determinants of children's health are social and originate or are experienced within the context of their families. Children's health and well-being is directly related to their families' ability to provide their essential physical, emotional and social needs. Families' success in meeting their children's needs is related, in turn, to their own life circumstances, social supports, and status in the economic and social hierarchies in which they live.<sup>1</sup>

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In the United States, the degree of engagement of families with one another and with the civic and social organizations that shape their lives is declining, and so is their opportunity for support within their communities.<sup>2</sup> Families are losing their sense of belonging to a community—communality—and with it they are losing both real and perceived access to social support and a sense of coherence to their lives. This is especially troublesome for poor families who have greater need for such supports to carry on day to day. When families are poor, their daily lives, including their interactions and relationships, are colored by poverty, and families' functioning is challenged if not diminished. Only by addressing root causes of the social isolation and disengagement of families from the broader resources of society can the functioning and thus the health of children, especially poor children, be improved and sustained.

One need only look within the United States for evidence of the importance of social factors to children's health. Despite living in the country with the world's highest per capita expenditure for health care,<sup>3</sup> many children in the United States are not faring as well as might be expected, particularly regarding health outcomes. The United States compares unfavorably to almost all other countries with comparably developed economies in terms of rates of low birth weight and of infant and post-neonatal mortality.<sup>4</sup> Similarly, rates of child abuse,<sup>5</sup> teenage pregnancy,<sup>6,7</sup> unintentional injuries,<sup>8</sup> and teenage suicide<sup>9</sup> and homicide<sup>10</sup> are higher in the United States than in most other developed countries, and disproportionately so among poor children and youths.<sup>11–15</sup> Further, trends in rates of child behavior problems,<sup>16</sup> youth homicide,<sup>17</sup> child abuse,<sup>18</sup> pediatric HIV infection,<sup>19</sup> teenage pregnancy,<sup>7</sup> teenage drug use,<sup>20</sup> and limitations of activity associated with chronic illness<sup>21</sup> are going in the wrong direction. These trends are punctuated by a 180% increase in suicide by children of ages 5 through 14 since 1979.<sup>22</sup> All of these problems share a common characteristic: they are not principally health problems—they are *social problems with health consequences*.

The very high value people place on traditional family life (e.g.,

Gallup Poll, April 7, 1991)<sup>23</sup> has contributed to the increasing but unfair belief that the failure and breakdown of American families are to blame for these social problems.<sup>24,25</sup> That conclusion overlooks the fact that families exist within a larger society and that social factors exert powerful influence on families' functioning and thus on children's health and well-being.<sup>1</sup>

In this paper, the social basis of parenting is reviewed with special attention to the effects of poverty and social inequality on family functioning. An argument is made to improve children's health by requiring that professional services as well as social policy and programs purposefully promote communality and, thus, more effectively support families in their child-rearing roles.

### ***The Functions of Families***

A framework of what is expected of families would help efforts to support families in their child-rearing functions. The following taxonomy of these family functions is proposed: (1) material and instrumental, (2) emotionally supportive, (3) socializing, and (4) educating.<sup>26</sup> Families are, or at least are supposed to be, children's first and most important source of support and care. At the most basic level, families are to be the source of *material support* for their children—providing food, clothing, shelter, and a clean and safe environment,—and of *instrumental support*—ensuring that children get to school regularly and to the doctor when they have need. Families are also expected to provide *emotional support*, so that children feel loved and valued and part of a group of people who communicate intimately with and have obligations to one another. In addition, families are supposed to *socialize* children, to teach them to respect other people and how to behave with their family and friends and in public. Finally, families are to *teach* children how to make their way in the world, how to responsibly carry out daily tasks and cope successfully with stress and adversity.

Families that carry out these functions well tend to have members who spend time together communicating clearly, honestly, and frequently. They also are committed and mutually supportive

of one another, cope well under stress, and are part of a network of friends and relatives.<sup>27</sup> A variety of public opinion polls have shown that most people in the United States recognize the special importance of these aspects of family life and believe that they should be promoted.<sup>24,28</sup>

### ***Changes in Family Structure***

When these aspects of family life are present, there is a strong likelihood that families will be able to successfully carry out their requisite functions. However, the socioeconomic environment in which families find themselves today often hampers families from achieving such ideal relationships and makes rearing children more difficult than in the past.<sup>29</sup> Profound changes in the economy and society over the past two decades have left fewer families able to rear children independently, without outside assistance. Two key social trends merit brief review.

#### **Single-Parent Families**

Single-parent families now comprise 30% of all families with children, double the proportion two decades ago. Two factors have contributed to this change in family structure. First, the percentage of children living with a single, divorced mother tripled between 1970 and 1993.<sup>30</sup> Second, the proportion of children living with a single, never-married mother increased nearly eightfold during the same time.<sup>30</sup> Cumulatively, of children born in 1980, roughly 70% of white children and over 90% of African-American children will spend part of their youth in a one-parent family.<sup>31</sup>

#### **Working Mothers**

Women's participation in the labor force has increased substantially during the past generation.<sup>32,33</sup> In 1960, only 28% of married women with minor children were in the labor force, but by 1992 that figure had risen to 68%.<sup>34</sup> Many, sometimes complex, explanations have been offered to account for this trend, but most women who work outside the home do so either because their husband's income does not meet their families' needs or because

they are single or divorced mothers and work to support their children.

### ***Consequences of Family Changes***

These changes in families' structure and mothers' roles have had important consequences for families' functioning and children's life experiences and outcomes. Three of these consequences, only one of which is economic, are especially problematic—*income poverty, decreased parental supervision of children, and time poverty.*

#### **Economic Consequences**

The increase in female-headed households, the low wages available to most women, and the limited hours for work available to a household head with dependent children, coupled with lack of support from absent or estranged fathers, results in more mothers and children being poor.<sup>35,36</sup> Nearly half of the increase in child poverty rates since 1980 can be attributed to changing family structure.<sup>37</sup> The median family income for female-headed households with children, about \$13,500, is less than a third of that of a married couple with one or more children.<sup>38</sup>

#### **Supervisory Consequences**

Parents' decreasing ability to monitor their children, the second consequence of recent changes in the family, arises from the need for both parents or for the sole parent to work. When parents work, someone else needs to supervise their children. Fully 48% of children under age 3 and 54% of children under age 6 are cared for by someone other than their parents,<sup>39</sup> and the quality of much of that care has been seriously questioned.<sup>40</sup>

For school-age children, non-parental supervision may mean pre- and after-school care programs, or, for too many so-called latchkey children, no supervision at all until a parent gets home from work.<sup>41</sup> In the United States, about 7% of children aged 5 through 13 and about 15% of children aged 5 through 17 are without adult supervision after school,<sup>42</sup> and self-care is somewhat

more common in single-mother households.<sup>43</sup> Unsupervised children are more likely to undertake risk behaviors (i.e., alcohol, tobacco, and other drug use), to be depressed, and to perform poorly at school.<sup>44</sup> These predilections for risk vary with parents' knowledge of their children's whereabouts, with the amount of time children are in self-care, and with other developmental and sociodemographic factors.<sup>43–45</sup>

### **Time Consequences**

Both poverty and parental employment, separately or combined, can deprive children and their parents of adequate and good-quality time together and create a new kind of poverty—time poverty.<sup>35</sup> Potential parental time (total time minus time in paid work) has declined significantly over the past several decades.<sup>46</sup> This time decrease is strongly related to employed mothers' decreased availability to their preschool-aged children.<sup>47</sup> Lacking material resources such as washing machines, automobiles, and other conveniences such as easy access to supermarkets and health care that make daily chores less time consuming, some poor parents are especially short on time for their families.<sup>48</sup>

Notably, parents report that the portion of time with children that is most likely to be short-changed is time “having fun”.<sup>47</sup> Mothers' feelings that they have “the right amount of time” with their children decrease as the number of hours they work each week increases.<sup>49</sup> A national survey of adults in 1991 found that 59% believed that the amount of time children have with their parents is less than it was 10 years earlier.<sup>50</sup> However, it is not clear that children either benefit or are harmed by maternal employment *per se*. Children's outcomes reflect the interaction of a great number of biological, psychological, and social factors. Whether and why their mothers work is only one set of contributing factors.<sup>51</sup>

### ***Poverty, Stress, and Family Functioning***

Clearly, the health and well-being of some children will be compromised when their families' income, supervision, and time

together is diminished or otherwise inadequate. The mechanisms by which these family circumstances, especially poverty, affect parents and parenting must be understood before effective policies and programs to compensate for them can be developed.

### **Meeting Children's Needs**

Though the structure and functioning of the family in America has changed, the basic needs of children have not. Families vary as to how independently they care for their children, but all families rely on others to some extent to meet fundamental obligations to their children. For example, child care, secular education and religious training, and medical care have long been provided by a variety of family resources, agencies, and institutions. Thus, when families cannot, for instance, supervise their children or afford medical care, enterprises such as for-profit child care or public programs like welfare (AFDC) or Medicaid are available to substitute for parents.

Interfering with the development of family support programs is the persistent prejudice that dependence on social programs to provide basic material goods and instrumental services is *prima facie* evidence of diminished family functioning. The obverse, i.e., having sufficient wealth to purchase these goods and services on the open market, is presumably indicative of better moral character and family functioning. Such stigmatizing of the poor is unwarranted and insupportable and impedes progress toward improving outcomes for children. For children, in the long run, the important difference is not who provides material support but rather how well their needs for emotional support, socialization, and education are met.<sup>52</sup> The rise in nontraditional families has had an impact on children's well-being by diminishing parents' ability to provide the time-intensive, emotion-laden attention children require. In a household survey, the rates of feelings of loneliness or of feeling sad were lowest for children (ages 10 through 17) of intact families, higher and about equal for children in single-parent and step-parent families, and highest for children living out of home.<sup>49</sup> It seems that rearing children is not a job for

strangers. This family role is not easily assumed by others less emotionally vested in the child's success and happiness.<sup>53</sup> Socially isolated, unsupported parents, for their part, may be nearly as unable.

Successful child development requires high levels of motivation, attentiveness, sensitivity, and persistence on the part of both the caregiver and the child. These requisite qualities are more likely to arise and be sustained when interactions between child and caregiver occur on a regular basis over an extended period of the child's life.<sup>52</sup> Although recent decades have disclosed and sanctioned a wide variety of family constellations, none of which is predestined to fail to meet children's needs, even the progressive child-development expert Bronfenbrenner has argued that two adults, preferably a mother and father, can raise a child better than one, and others have provided data to support that contention.<sup>52,54-56</sup> Most parents, too, seem to subscribe to that conservative belief, as 84% of women with children under 18 years of age felt it was "very important" to be able to share child-rearing responsibilities with another adult.<sup>57</sup>

### **Social Class and Child Rearing**

Single-parent households are most common among the poor, and poverty denies families many resources that facilitate child rearing and favor normal child health and development. Some of the resources are material and include, for example, a safe environment, adequate housing, nutrition, and medical care. However, it is not families' ability to provide materially *per se* that is of paramount importance for child outcomes. Support and understanding are more important. It is self-evident that poverty can jeopardize a family's ability to provide for its children's essential material needs. It may be less evident, but it is equally true, that poverty and the psychological distress it engenders can interfere with a family's ability to meet its children's needs for emotional support, socialization, and life-skill education.<sup>35,58</sup>

Poverty and social class differences based on parents' education and occupation affect children primarily through their impact on

the affective aspects of family functioning and consequent child-rearing practices.<sup>59–63</sup> Child rearing in low-income families tends to be less warm, supportive, stimulating, and verbally responsive; more authoritarian and punitive.<sup>58,64–66</sup> Class differences in child-rearing techniques cannot be ascribed to a solitary factor, but rather arise from the structural context of advantage and disadvantage. People who are poor are also more likely to be single parents, to have been divorced, and to have experienced family conflict and violence, racial and ethnic discrimination, unemployment or low-status employment, and low levels of educational attainment. The cumulative effect of all these stresses strains a family's ability to function as a supportive unit and contributes to lower self-esteem and higher rates of depression among poor parents.<sup>67</sup> The amount of stress experienced by mothers is related to the frequency of adjustment problems among children<sup>68</sup> and, conversely, the ability of parents, particularly mothers, to cope with stress can reduce children's risk for emotional problems.<sup>69</sup> One of the most powerful coping mechanisms is the availability of a network of supporting relationships.<sup>70</sup>

The consistent health disparities between black and white children may have some of their bases in the social disenfranchisement and isolation that accompany lower social class status and influence family functioning and integrity. For the most part, in these comparisons race is used as a proxy for one or several elements of social class—income, education, and occupation. Race has served reasonably well in this regard, since racial minorities, especially black families, tend to have lower incomes, less accumulated wealth, lower high school completion rates, and lower-status education. Besides the bias inherent in such an extrapolation or substitution, however, using race as a proxy for class minimizes the social and psychological consequences of being a member of a racial or ethnic minority in the United States and, in turn, their effect on health. There are numerous examples of persistent racial differences in health when income, occupation, and even education are controlled in the analyses.<sup>71–75</sup> The apparent effect of race on health operates in part through racism—an

ideology that categorizes and ranks groups of people, with some being inferior to others. Racism can affect health by transforming social status, and so can determine the degree of exposure to risk factors and resources, and directly affect health through its effects on psychological and physiological functioning.<sup>76</sup>

### **Social Isolation, Social Supports, and Social Capital**

Many of the adverse effects of poverty on the child-rearing functions of families emanate from parents' sense of social isolation and lack of reliable sources of social support. Improving parenting is best accomplished by the joint provision of instrumental and emotional support to families.<sup>65</sup> When parents themselves feel supported and competent, cared for and valued, and when they also receive instrumental child-focused help such as baby-sitting, they are much more able to cope with their lives and to provide socially and emotionally for their children.<sup>65,77-79</sup> There are many public- and private-sector community-based family support programs that provide such support in the form of information, emotional support, feedback and guidance, and practical assistance.<sup>80</sup> Such programs serve both a preventive and enrichment function for children and a growth-enhancing function for parents, and thus strengthen both the family unit and the community.

When the social networks that families form are characterized by mutual trust and obligation, the social capital created is greater than the sum of what individual families contribute.<sup>81</sup> Children who live where overlapping relationships create an abundance of such capital, where families feel a part of a community, are likely to be less susceptible to the effects of poverty.

### ***Socioeconomic Status and Child Health***

Both theory and a variety of research endeavors support the idea that poverty has its effects on children's health through its tendency (1) to reduce parents' personal resources as well as (2) to isolate families from sources of social support. Further evidence

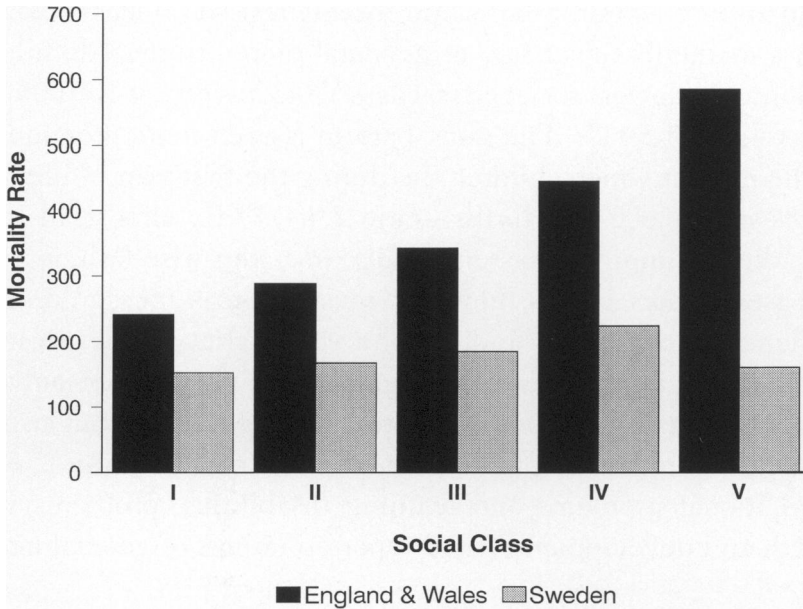


FIG. 1. Postneonatal mortality per 100,000 live births (1985 to 1986) (married or cohabiting couples).<sup>81</sup>

for the social determination of child health comes from large-scale studies, where the relationship between socioeconomic status and health has been investigated.

Poverty and the associated conditions of low levels of educational attainment and low occupational status understandably have an effect as adverse on children's health as they do on family functioning. Poverty is the best predictor of poor health outcomes for children,<sup>82</sup> yet the mechanisms through which poverty operates to impair health remain a puzzle. The high death rates of children on welfare and their higher rates of chronic health problems and disabilities may be related to poor families' more limited access to health care.<sup>83–87</sup> However, the notion that access to care is the sole or even primary explanation for the disparity in health between the poor and the non-poor is unfounded.<sup>82</sup>

### The Socioeconomic Gradient

In England and Wales (Fig. 1), where universal health insurance is well-established and fiscal access to care is assured for the poor

and non-poor, children born into the highest social class, Class I, have a markedly lower rate of neonatal mortality than do infants born into the lowest social class, Class V (432 vs 663 of 100,000 live births—ratio 1.5:1).<sup>88</sup> The same pattern is even more pronounced for the rates at which children die during the first year of life (241 vs 584 of 100,000 live births—ratio 2.4:1).<sup>88</sup> By almost all measures, health improves systematically, in a step-wise fashion, with increases in social class, however social class is measured. This gradient is a consistent finding for a wide variety of health measures for children and adults. A gradient is present not only for neonatal mortality and post-neonatal mortality (Fig. 1) but also for such diverse measures of child health as nutritional status,<sup>89</sup> rates of emotional problems and learning disabilities, problems with growth and development,<sup>90</sup> and reported ratings of general health status.<sup>91</sup>

The slope of the curve, indicating the amount of change in health with each change in social class, is more pronounced at lower levels of class and income. What is remarkable and as yet unexplained is that the pattern of improving health status often persists even at the highest points on the social-economic scale. It is perhaps understandable that people in the middle should have better health than those in the lower classes. It is more difficult to explain why the wealthy should be in better health than the well-to-do. In their study of British civil servants—overwhelmingly of one ethnic group, with one employer, in one geographical district, in stable employment, not exposed to physical environmental hazards of factory and outdoor work—Marmot and Theorrel<sup>92</sup> found that a gradient was apparent both in overall mortality rates and in deaths from cardiovascular disease. This even occurred between the highest levels of employees, whose class differences reflected social status as much as purchasing power. Since socioeconomic status is a family characteristic and not merely an individual one, it is reasonable to assume that this gradient would apply to family members, including children, as well as to the breadwinner.<sup>93</sup>

### Social Inequality and Health

One important aspect of the relationship between social class and health may help to clarify gradient effects. Compared to the infant and post-neonatal mortality data from England and Wales, comparable data from Sweden, which also has universal health insurance, shows a much less pronounced gradient effect. Superimposed (Fig. 1), the data from the two regions demonstrate that post-neonatal mortality in Sweden is much lower at all levels of income than it is in England and Wales. What is the explanation for this difference?

Wilkinson<sup>94</sup> has proposed that it is not the greater affluence of Sweden that accounts for these differences in mortality (1992 gross national product per capita was \$17,790 in the United Kingdom and \$27,010 in Sweden);<sup>4</sup> rather he ascribes these differences to Sweden's lesser income inequality compared to England. Wilkinson ranked nine industrialized countries by their gross per capita income, and found that, at least in these countries, *average* national wealth is not strongly related to health. Certainly, data on infant mortality rate and life expectancy that compare the United States to other developed countries supports this conclusion.<sup>3</sup> Wilkinson also compared European countries in terms of increases in their gross national product per capita during the years 1970 to 1990, and likewise found no significant relationship between economic growth and changes in life expectancy.<sup>94</sup> He then ranked the same countries by the proportion of income that went to the least-affluent 70% of families<sup>95</sup> and compared life expectancies of the countries. He found that the countries with the least difference in income between the upper and lower classes had the longest life expectancy, and vice versa. He also found that it is not the extreme poverty of a small minority of the population and their shortened life expectancy that pulls down the mean for each country, but rather the inequality experienced by the least-well-off 70% of the population among countries. Wennemo<sup>96</sup> subsequently found that countries with the highest infant mortality rates tend to be those where the proportion of the population in relative poverty is greatest.

A more encompassing measure of the health of children showed a similar association with income inequality. Miringoff compared 10 nations (West Germany, Japan, Italy, Spain, Norway, Australia, France, Switzerland, United Kingdom, and the United States) using an index of the social health of children incorporating infant mortality, public expenditures for education, teenage suicide, and income distribution. Between 1970 and 1989, substantial declines in this index occurred only for children in the United Kingdom and the United States.<sup>97</sup> In another study, both of these countries placed in the top one-half with regard to income inequality; the United States ranked first.<sup>98</sup>

Although the socioeconomic gradient effect for health and the consequences of income inequality is most pronounced for the poorest segment of societies, it is not restricted to the lower class and increasingly will be an experience of the middle class. In the United States in 1993, while the least-well-off 20% of the population earned only 3.6% of the gross national income, unchanged from 1990, the most affluent 20% of the population earned 48.2%, up nearly 4% since 1990.<sup>30</sup> These data suggest that social support programs will be needed by an increasing proportion of families in the United States.

This and other research is finding that in developed countries where abject poverty and lack of access to food, shelter, and safe water supplies are not serious problems, the bad health of the poor may not reflect their lack of income and resources so much as their relative deprivation when compared to others. Poor health, in other words, and perhaps other measures of the quality of lives, may be due, in large part, to the experience of social inequality that the unequal distribution of income engenders.

### ***Social-Psychological Mechanisms***

How could relative deprivation, differences in social status, affect physical health? Though there are many mechanisms by which social inequality impairs family functioning and thus dimin-

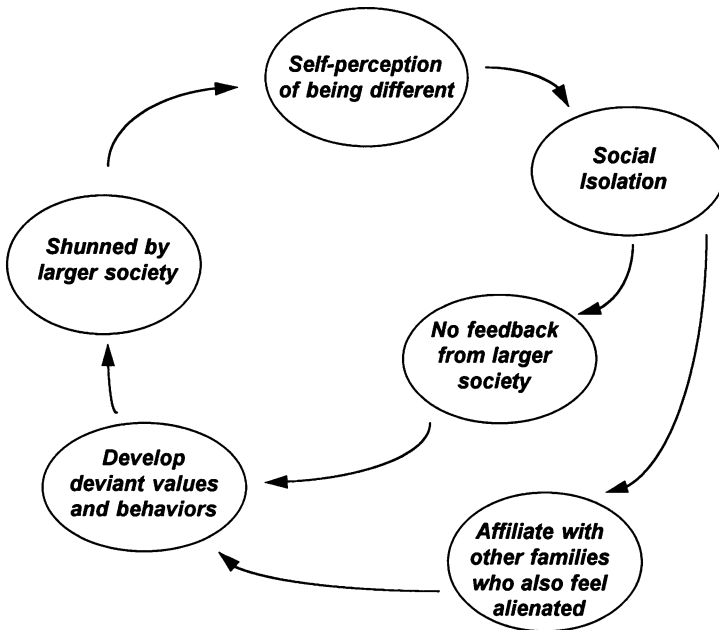


FIG. 2. Social isolation and the cycle of deviance.

ishes the health of children and parents, two of the most interesting mechanisms are related to position in the social hierarchy.

The first involves *social isolation and the cycle of deviance* (Fig. 2). The greater the social inequality, the more the have-nots will feel and be isolated from mainstream values and behavioral norms. Families socially isolated in this way have fewer opportunities to learn alternative ways of responding to adversity and of living their lives. They are less subject to informal social control, such as worksite protocols that shape behaviors to conform to social expectations.<sup>58,61,99,100</sup> Such families identify and affiliate with others who are similarly marginalized within the larger society. They try to maintain stability and make sense of their world by developing patterns and styles of coping—styles that often are unique, dysfunctional, and deviant ways of behaving. They may, for example, promote teenage parenting, which encourages and justifies intrusive and enmeshed relationships with extended families. Or they may view and approach the world as inherently hostile and take on aggressive and antisocial ways of relating. They may also

seek solace by using and becoming dependent on alcohol or other drugs. Predictably, and unfortunately, the family's deviance becomes part of its children's social repertoire and serves only to further isolate them from the majority of their peers.<sup>63,101</sup> But, by far, the most profound consequence is the resignation and passivity that these families may acquire, a fatalism and futility about their lives and about changing their communities and their places in them.<sup>102</sup> Unfortunately, as evidenced by public opinion polls and rates of participating in elections and the political process, these feelings are harbored by a sizable and increasing proportion of citizens. These trends weaken the foundation of participatory democracy and suggest that only interventions that address the bases of social inequality are likely to effectively promote social integration and improve health.

A second way social inequality can lead to family dysfunction is through the *frustration of aspirations* to advance up the social class hierarchy.<sup>103,104</sup> Until recently, middle-class Americans believed that successive generations would experience a higher standard of living and less social inequality through individual effort and general improvement in the economy. As has become apparent, this belief is not well supported by fact. First, just because new jobs are being created does not mean that the income of the poor will increase. Recent experience has shown that new jobs may simply mean more poorly paying jobs. Second, if everyone's standard of living improves equally, the poor are, relatively speaking, still no better off—they remain relatively deprived (Fig. 3).<sup>105,106</sup> For example, as a country becomes richer, it takes more income to buy enough commodities to maintain the same level of social status that one had before the economic improvement. Thus, aspirations to change social class are frustrated. Today, for the poor in the United States the ante for social advancement—ostensibly the cornerstone of the American dream—has gone up, and other attributes of the higher social classes (e.g., higher education, stable employment, and a sense of control and coherence) remain out of reach. The significant shift in capital between 1990 and 1993 from the middle to the upper class similarly limited the opportunities

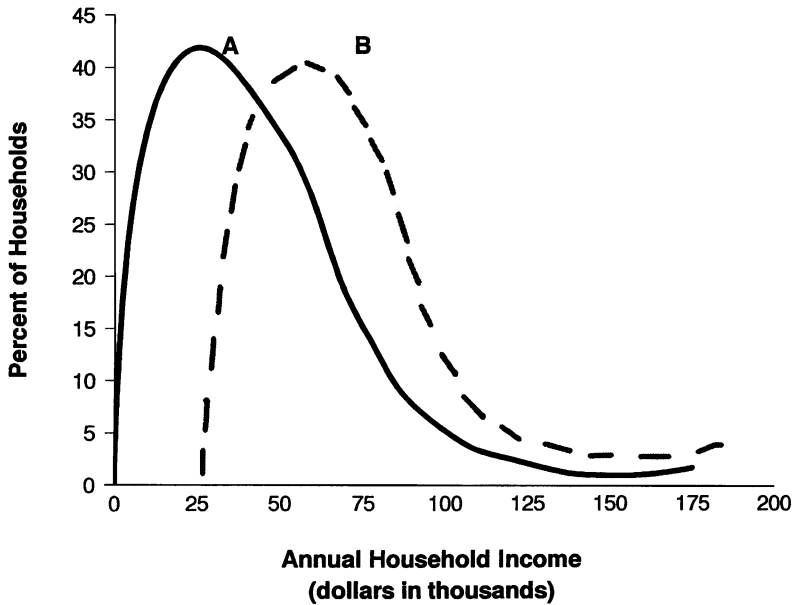


FIG. 3. Distribution of population income and frustration of aspiration (1990 Census population).<sup>98</sup> A: actual income; B: income shifted upward.

for social advancement of the middle class as income inequality increased between those groups.<sup>30</sup>

### ***Taking Steps: Social Capital and Family Support***

What can be done to respond to the striking changes in the life circumstances of the average family and in the diminished opportunities to improve their quality of life? One step toward reversing the trend toward social inequality and promoting social advancement in the United States, most unlikely in the present political climate, is the adoption of economic policies that support income redistribution. A second, and perhaps more feasible strategy is to focus on the “social” end of socioeconomic disparity and address the fundamental lack of a sense of communality and mutual interdependence in society.<sup>2,81</sup> The existence of income inequality, the rise of homeless people on our streets, and opinion polls indicating a diminishing sense of public responsibility for the needy, all signal erosion of a core social value, the commitment of

Americans to one another.<sup>107</sup> This is a major impediment to improving society and takes its greatest toll in diminished quality of life, including health, for poor families. What must precede social development and the improvement of health and well-being is not only economic betterment but also the enhancement of social capital. New enterprise will succeed best when it is located where there are strong social ties and a sense of community.

Social capital, like human and physical capital, is productive in that it makes possible the achievement of certain ends that would otherwise not be attainable. Unlike other types of capital, however, social capital is the product of social exchange. It rests on the presence of social networks, communities of people who know one another and whose relationships are characterized by norms and by mutual trust and obligation. While some may feel that material success and social development rest on economic well-being, the opposite is equally and perhaps more true. The existence of social capital has been shown to precede economic and social development.<sup>108</sup>

Adolescents attending parochial schools, for example, have lower drop-out rates even than adolescents in secular private schools, presumably because their parents' lives overlap in multiple spheres (e.g., through the school their children attend and the church to which they belong).<sup>81</sup> Social capital is greater for such families than for those who participate in only one rather than two institutions. In the face of poverty and socioeconomic inequality, children's health and quality of life are likely to improve when their parents have access to social capital—when they feel they belong to a community—and, thus supported, are able to function better in their child-rearing roles.

What can professionals in communities do to create social capital for families and children, especially those experiencing economic deprivation? To borrow from the environmental movement, "Think globally and act locally." In this case, thinking "globally" means formulating and operating from a philosophy of human relationships and citizenship that promotes building *communality*—creating a sense of community within neighborhoods, towns, and

the nation. Acting “locally” means linking families to sources of social support—material, instrumental, and emotional—within their communities.

### **Building Communalities**

There is a growing ennui and indifference toward civic participation in the United States as evidenced by the declining participation of citizens in elections. In addition, participation in social and civic clubs (e.g., fraternal groups), organizations (e.g., PTA), and activities (e.g., bowling leagues) is also on the decline.<sup>2</sup> The lack of participatory civic forums, formal and informal, coupled with a concentration of political power in a professional elite,<sup>109</sup> has decreased the general sense of civic obligation. There are fewer incentives and opportunities for individuals to take responsibility for themselves, their families, and neighbors—not to mention strangers—and a diminished expectation to hold themselves and other individuals accountable for their actions in the social context.

What has been lost is a sense of communality—a network of relationships and a set of understandings above and beyond the individual that are part of the natural order of everyday life—a degree of trust within a community.<sup>102</sup> At a micro-level, within and among families, continuity and history that derive from a sense of place and from values that are handed down through generations, are lost. Related, there is a declining awareness of intergenerational obligations by which we convey from parents to children, and from children to parents, responsibility to care for the persons and things entrusted to us.<sup>110</sup> At the level of communities, the decay or abandonment of public institutions in which citizens meet face to face—with little regard to race, class, religion, or national origins—has led to a decrease in the opportunities for citizens to debate one another, to learn to appreciate and respect diversity, and to identify a moral infrastructure of shared values. Much as children need extensive attention from devoted parents to develop and flourish, so social institutions require citizens’ attention.<sup>110</sup>

While the barriers to developing communality are formidable, improving the health and well-being of children and families requires that they be overcome. Some “global” policy recommendations, rules for public behavior, can be offered to those who formulate policy on how to proceed to create social capital:

- Publicly debate the gross inequalities of both role and opportunity that exist. Child advocates must address the causes and consequences of the feminization of poverty and the lack of supports for families trying to provide both material and emotional necessities to their children.
- Foster mutual obligation among individuals, families, and organizations based on articulated ethical judgments. All citizens, but especially those whose opinions and behavior is trend-setting, must take public responsibility for others by making direct and personal contributions to the public good.
- Engage in long-term thinking and planning. In personal and work life, commerce and policy, focusing on immediate gain and gratification interferes with relationship-building and extended commitments to people, places, and ideas. Individual and group decision-making should emphasize socially defined, long-term goals.
- Promote overlapping domains of personal activity. The separation between work and home community, for example, does not allow the advantage of mutual interest and reinforcement to occur; the production of social capital is inhibited.
- Enhance intermediary social institutions (e.g., child care, school, worksite, church, and social clubs). These must change their objectives, programs, and, in some cases, governance, so that they can increase their involvement with families.
- Appreciate diversity, acknowledge individual worth, and recognize shared values by means of dialogue. Programs and services, even those that focus on individuals, should build in opportunities and incentives for individuals and families to interact face to face.

**Family Social Support**

Local action to create social capital can be guided by the extensive experience of communities that have developed family support programs. These programs take many forms, but all provide the support that assures that families have time together and have the resources and guidance to make full use of that time to nurture relationships between spouses and with children. It is central to family support programs that they help families feel as though they are part of a network of caring and mutual obligation. To provide such support means offering services that are family-centered and that link expectations and goals with tangible means to achieve them; services that provide real and realistic opportunities to grow; services that protect, nurture, motivate, structure, mediate, teach, and enable; and services that act as a psychological safety net for families to falter without falling.<sup>111</sup>

A large number of public- and private-sector community-based programs have been and continue to be established, programs that provide social support in the form of information, emotional support, feedback and guidance, and practical assistance to families.<sup>80</sup> Social institutions and community organizations have begun to offer a variety of family services that may substitute for or assist families. Home visiting, early screening and referral, parent support, parenting education, and drop-in play are programs commonly found in communities. Schools provide after-school programs for children whose parents cannot be at home when classes end and school-based health services to assist children to receive timely health care and health counseling. Curricula have expanded to include value-laden topics such as conflict resolution, sex education, and community service, topics that previously were the nearly exclusive domain of parents. Employers offer a menu of family benefits such as flexible work hours, shared jobs, and child care. Government programs such as welfare, Head Start, and Medicaid have supported poor families with children, although their intended and actual role in recent years has been much debated.

There have been a large number of projects, some of which

have been evaluated, and a much smaller number of research projects that have applied some form of family support interventions to improve child health outcomes. The general characteristics of successful programs have been described,<sup>112</sup> but replications are few and there has not been enough high-quality research to reach definitive conclusions about their optimal content.<sup>113</sup> However, the conclusions that successful programs provide intense, long-term, flexible services, and are comprehensive and well-staffed, has received quantitative support from research on home-visiting programs. Visiting the home of pregnant women, infants, and young children has been effective in reducing low-weight births and enhancing cognitive development. Home visiting has also had some impact on child abuse and neglect, particularly by improving parenting conducive to positive social development. Programs that are designed to address specific behaviors or skills, e.g., health care use and care of children with special health care needs, have also met with some success.<sup>114</sup>

Many efforts to improve outcomes for children and families subscribe, at least in theory, to an ecological model. However, few programs have attempted, and rarely have any succeeded, in addressing the socioeconomic and cultural environments in which health behaviors and decisions take place.<sup>115</sup> One of the arenas wherein some success has been shown is school-based interventions. Schools are viewed both as communities for children and as part of the larger community in which they operate.<sup>116,117</sup> Schorr<sup>112</sup> reported on the success of Dr. James Comer in improving schools in New Haven, and quotes Comer as saying, "It is the creation of a sense of community and direction for parents, school staff, and children alike ... it's essential to address the entire social system of the school." Dryfoos<sup>118</sup> describes two examples of institutions that have become community schools/full-service schools where a full complement of education, health, recreation, and social services were made available to students and to other members of the community through public-private partnerships. Early evaluation data point to some success.

The best family support programs implicitly foster a sense of

community among participants and create social capital within communities. They operate on the following principles:

- Providing support during the early years of parenthood serves both preventive and enrichment functions for children and a growth-enhancing function for parents.
- Families are part of a community and support should be provided in the context of community life and through links with community resources.
- The needs of parents should determine the kinds of support provided.
- Support should build on the strengths that whole families and individual family members already have.
- Support should aim to strengthen the family unit and the community while preventing alienation and family dysfunction.

Effective family support also offers a sufficient breadth of integrated or at least coordinated services and programs so that families feel themselves part of a system to which everyone, rich and poor, can and does have access. The notion that only the poor and disenfranchised families need help raising their children is no longer tenable—if it ever was. To promote communality and build social capital, family support programs should serve entire communities whose families have a wide diversity of needs, rather than focus exclusively on narrowly defined groups of high-risk, poor families. When families feel supported by a sense of shared values and social bonds they often can succeed where, before, failure seemed likely. When families' goals are the goals of their community, successfully raising healthy children, even in deprived circumstances, is less difficult.

There is a tragic irony in the usual current approaches to reducing teenage pregnancy, the incidence of low birth weight, child abuse, and other social health problems. Despite a clear recognition that comprehensive, "ecological" approaches are needed, older efforts that have not proven successful continue and new efforts of limited scope and promise are begun, largely because they can be funded through existing categorical programs. However, the problems with short-sighted, narrowly focused interven-

tions have been recognized. Some communities and states have begun efforts to meld funding streams, collaborate across disciplinary and bureaucratic lines, and develop collaborative and, it is hoped, integrated community-based programs. The Healthy Start Programs funded by the US Department of Health and Human Services subscribe to the philosophy of collaboration<sup>119</sup> and cities such as Rochester, NY, are trying to develop comprehensive, coordinated, and integrated services.<sup>120</sup> More than 50 national organizations joined to draft a document outlining the principles of integrated, community-based, school-linked programs.<sup>121</sup>

The recent trend to adopt outcome-based accountability for social programs is likely to reinforce the decision to provide integrated, community-based models of service delivery.<sup>122</sup> However, while these steps toward collaboration and integration are reason for optimism, substantial inertia must be overcome before they move from being community-based to community-focused.

### ***Conclusion***

The recommendation to “think globally” to create a sense of community and “act locally” by developing and maintaining family support programs may seem a long distance from the individual health problems of children and the role of child health professionals. But the quality of the lives of children and families, and professionals’ ability to improve their health and well-being, is intimately tied to the nature of civic society and the availability of social capital.

Several scholars who have identified the characteristics of successful interventions for children<sup>106,107</sup> have been left with the question, Why have we made so little progress *applying what is known*? This paper argues that many of the most vexing health problems of children and adolescents are symptoms that have their origin not in biologic processes but rather in the economic and social inequalities between classes. Those inequalities create not just material deprivation but a poverty of spirit. That poverty rests on a disparity of perceived self-worth and a dependency on too-

distant social institutions to define that worth and to provide opportunities to participate as members of a civic society. Certainly, at a national level, greater social and economic equality is an obtainable goal. If class disparities in child health are to be reduced, this must be the goal toward which social policy is directed. By promoting policies that foster communality, and by working within local communities to support families in their child-rearing functions, progress can be made. The first step toward achieving more-equal status rests on the actions of individuals, especially professionals in work roles and as participants in their communities. While the establishment of a sense of communality can be facilitated by political action, its ultimate success rests on personal initiative and behavior.

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